McLaren Business Products

**McLaren Print System Order**

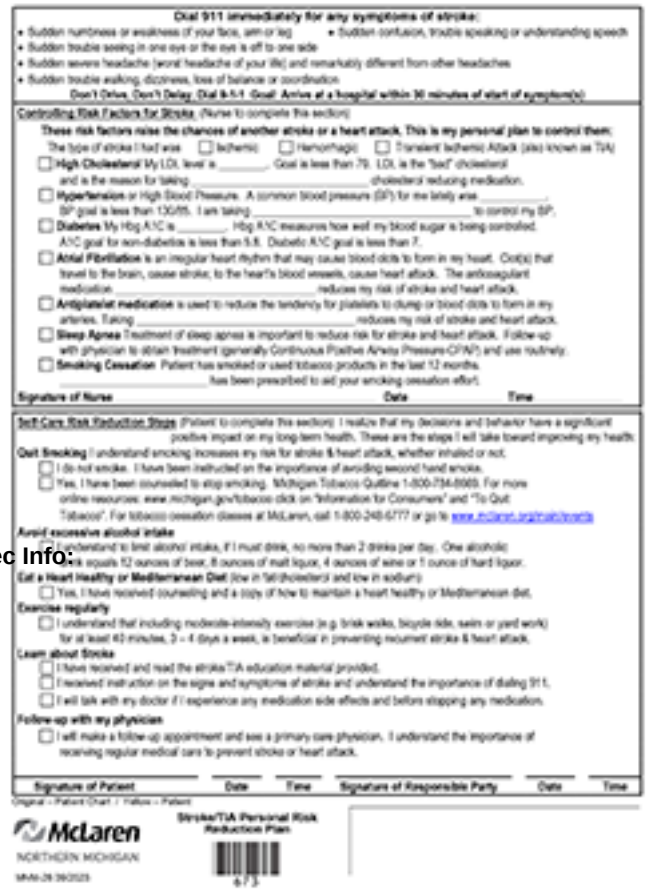
**Order No: 83944**
**Order Date: 2024-03-21**
**User: Ann  Wallace**
**Phone: 5179757311**

**Ship Location:  McLaren Greater Lansing Office 1-234 Attn: Ann**
**2900 Collins Rd**
**Lansing, MI 48910**
**Forms**
**Quantity: 250**
**Paragon Dept No: 21600**
**Dept Name: Neuro Trauma**
**Company Number: 160**

**Order Total Price: 180.00**

**Item Number: MNM-28**
**Item Description: Stroke/TIA Personal Risk Reduction Plan**
**Revision Date: 09/2023**
**Print:**
**Paper:**
**Size:**
**Fold:**
**Finish:**
**Drill:**
**Poster:**
**Misc Info: SS, Black**

**Spec Info:**



**Dial 911 immediately for any symptoms of stroke:**

- Sudden numbness or weakness of your face, arm or leg
- Sudden confusion, trouble speaking or understanding speech
- Sudden trouble seeing in one eye or the eye is off to one side
- Sudden severe headache (worst headache of your life) and remarkably different from other headaches
- Sudden trouble walking, dizziness, loss of balance or coordination

**Don't Drive, Don't Delay. Dial 9-1-1. Goal: Arrive at a hospital within 30 minutes of start of symptom(s).**

Controlling Risk Factors for Stroke (Nurse to complete this section)

**These risk factors raise the chances of another stroke or a heart attack. This is my personal plan to control them:**

The type of stroke I had was ☐ Ischemic ☐ Hemorrhagic ☐ Transient Ischemic Attack (also known as TIA)

☐ **High Cholesterol** My LDL level is _____. Goal is less than 70. LDL is the "bad" cholesterol and is the reason for taking _____ cholesterol reducing medication.

☐ **Hypertension** or High Blood Pressure. A common blood pressure (BP) for me lately was _____. BP goal is less than 130/85. I am taking _____ to control my BP.

☐ **Diabetes** My Hbg A1C is _____. Hbg A1C measures how well my blood sugar is being controlled. A1C goal for non-diabetics is less than 5.8. Diabetic A1C goal is less than 7.

☐ **Atrial Fibrillation** is an irregular heart rhythm that may cause blood clots to form in my heart. Clot(s) that travel to the brain, cause stroke; to the heart's blood vessels, cause heart attack. The anticoagulant medication _____ reduces my risk of stroke and heart attack.

☐ **Antiplatelet medication** is used to reduce the tendency for platelets to clump or blood clots to form in my arteries. Taking _____ reduces my risk of stroke and heart attack.

☐ **Sleep Apnea** Treatment of sleep apnea is important to reduce risk for stroke and heart attack. Follow up with physician to obtain treatment (generally Continuous Positive Airway Pressure-CPAP) and use routinely.

☐ **Smoking Cessation** Patient has smoked or used tobacco products in the last 12 months. _____ has been prescribed to aid your smoking cessation effort.

**Signature of Nurse** **Date** **Time**

Self-Care Risk Reduction Steps (Patient to complete this section) I realize that my decisions and behavior have a significant positive impact on my long-term health. These are the steps I will take toward improving my health:

**Quit Smoking** I understand smoking increases my risk for stroke & heart attack, whether inhaled or not.

☐ I do not smoke. I have been instructed on the importance of avoiding second hand smoke.

☐ Yes, I have been counseled to stop smoking. Michigan Tobacco Quitline 1-800-784-8669. For more online resources: www.michigan.gov/tobacco click on "Information for Consumers" and "To Quit Tobacco". For tobacco cessation classes at McLaren, call 1-800-248-5777 or go to www.mclaren.org/main/events

**Avoid excessive alcohol intake**

☐ I understand to limit alcohol intake, if I must drink, no more than 2 drinks per day. One alcoholic drink equals 12 ounces of beer, 8 ounces of malt liquor, 4 ounces of wine or 1 ounce of hard liquor.

**Eat a Heart Healthy or Mediterranean Diet** (low in fat/cholesterol and low in sodium)

☐ Yes, I have received counseling and a copy of how to maintain a heart healthy or Mediterranean diet.

**Exercise regularly**

☐ I understand that including moderate-intensity exercise (e.g. brisk walks, bicycle ride, swim or yard work) for at least 40 minutes, 3 – 4 days a week, is beneficial in preventing recurrent stroke & heart attack.

**Learn about Stroke**

☐ I have received and read the stroke/TIA education material provided.

☐ I received instruction on the signs and symptoms of stroke and understand the importance of dialing 911.

☐ I will talk with my doctor if I experience any medication side effects and before stopping any medication.

**Follow-up with my physician**

☐ I will make a follow-up appointment and see a primary care physician. I understand the importance of receiving regular medical care to prevent stroke or heart attack.

**Signature of Patient** **Date** **Time** **Signature of Responsible Party** **Date** **Time**

Original = Patient Chart / Yellow = Patient

McLaren NORTHERN MICHIGAN

MNM-28 09/2023

**Stroke/TIA Personal Risk Reduction Plan**

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